

Dr Dagmar Whitaker

SEG (Frankfurt), MD (Frankfurt), M.MED. DERM (Stell)

Dermatologist * Mermatoloog

PR No 1201530

Even though we are a **Private Practice**, should you visit to claim back from your Medical Aid, please supply this information and it will be printed on your statement.

Medical Aid : Yes No Medical Aid Name : _____

Membership Number : _____

Referred to Dr Whitaker by (if applicable) : _____

MAIN MEMBER'S DETAILS

Title : _____ Initials : _____ Full First Names : _____

Surname : _____ Occupation : _____ Employer : _____

I.D. Number : _____ DOB : ____ / ____ / ____ Male / Female

Home Number : _____ Work Number : _____

Mobile Number : _____ Email Address : _____

PATIENT'S INFORMATION (If same as Main Member not necessary to repeat information)

Title : _____ Initials : _____ Full First Names : _____

Surname : _____ Occupation : _____ Employer : _____

I.D. Number : _____ DOB : ____ / ____ / ____ Male / Female

Home Number : _____ Work Number : _____

Mobile Number : _____ Email Address : _____

(If you Child is the Patient – please put the Patient's mobile number and Email address here)

PHYSICAL ADDRESS DETAILS (House / Unit Number, Estate Name, Street Name and Suburb – what must appear on Medical Aid Statement or Tax Statements)

_____ Postal Code _____

I hereby acknowledge that I will be personally responsible to settle my account on the DAY OF THE CONSULTATION.

Otherwise I will be held liable for interest that may accumulate and legal charges that may arise. I am fully aware that Dr Whitaker runs a Private Practice and does not liaise with any medical aids and that as a patient I must liaise with my own medical aid regards refunds, submission of accounts and other enquiries.

Signature : _____ Date : _____